NOTICE: THIS FORM MUST BE PRINTED ON 14 INCH PAPER

NJ STATE HEALTH BENEFITS RETIRED STATUS APPLICATION

New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299
Fax (609) 341-3407

HR-0075-0904

1. APPLICANT INFORMATION

Social Security Number ___ – ___ – ____

Were you a part time employee when you retired? ☐ Yes ☐ No

Last Name | Title (Jr., Sr., etc.)

First Name | Middle Name

Street Address | Apartment #

PO Box | City | State

Zip Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status (check one) ☐ Single ☐ Married ☐ Domestic Partnership (see instructions) ☐ Divorced ☐ Widowed

Area Code | Home Telephone Number | Date of Retirement (mm/dd/yy)

	YES	NO
Do YOU have Medicare Part A? (Hospital Insurance)		
Do YOU have Medicare Part B? (Medical Insurance)		
Does YOUR SPOUSE/DOMESTIC PARTNER have Medicare Part A?		
Does YOUR SPOUSE/DOMESTIC PARTNER have Medicare Part B?		

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

If your child has Medicare, list child's name and Social Security # _____ and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY

— Check one box in Section A; if you select ***New Retiree, Cancel Coverage,*** or ***Survivor Enrollment,*** skip to Part 3 Member Section. If you select ***Coverage Change,*** complete Section B; if you select ***Other Change,*** complete Section C.

A. ENROLLMENT ACTION REQUESTED

☐ New Retiree ☐ Survivor Enrollment: Decedent's SS# _____

☐ Cancel Coverage ☐ Coverage Change ☐ Other Change

B. COVERAGE CHANGES

Medical Plan Change — From _____ To _____

	Month	Day	Year
Marriage — Attach Marriage Certificate (Give Date of Event) Former Name _____			
Domestic Partnership — Attach Certificate of Domestic Partnership (Give Date of Event)			
Birth of Child (Give Date of Event)			
Adoption/Guardianship — Proof Required (Give Date of Event)			
Deletion of Dependent (Give Date of Event)			

Dependent's name: _____ SS# _____

Reason for Deletion: ☐ Death of Spouse/Domestic Partner ☐ Divorce ☐ Termination of Domestic Partnership ☐ Separation ☐ Other _____

C. OTHER CHANGES

☐ Spouse's Health Benefits terminated through employer — Attach letter from employer

☐ Change in last name only (Give Former Name) _____

☐ Correction to Social Security # — Attach copy of Social Security Card

(Give Former Social Security #) _____

☐ Change in Birth Date (Give Name and Correct Date) — Attach copy of Birth Certificate

_____

☐ Addition of dependent's Social Security # (List the dependent(s) in Section 5)

☐ Other: Give Reason Below (i.e., address change, dependent returns from military service, etc.)

_____

3A. MEDICAL COVERAGE (Check one box only).

☐ I wish to be covered under NJ PLUS Enter Your NJ PLUS Primary Care Physician's ID #

☐ I wish to be covered under an HMO. Name of HMO and # _____

Enter Your HMO Primary Care Physician's ID # _____

☐ I wish to be covered under the Traditional Plan

I do not wish to be covered under any of the medical plans for the following reason: (See instructions on Declining or Waiving Coverage)

☐ I have coverage under my spouse — Spouse's Public Employer _____

☐ I have coverage with another employer — List Employer _____

☐ Other (Give Reason) _____

3B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse ☐ Member & Domestic Partner (See Instructions)

☐ Family ☐ Parent/Child(ren)

4A. DENTAL COVERAGE

☐ I wish to be covered by the Retiree Dental Expense Plan

I do not wish to be covered under the Retiree Dental Expense Plan for the following reason: (See instructions on Declining or Waiving Coverage)

☐ I have coverage under my spouse — Spouse's Public Employer _____

☐ I have coverage with another employer — List Employer _____

4B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse ☐ Member & Domestic Partner (See Instructions)

☐ Family ☐ Parent/Child(ren)

4C. PREVIOUS DENTAL COVERAGE

Are you currently enrolled in another group dental plan (for at least 12 months) ☐ Yes ☐ No

If yes, please provide the following information: Dental Plan Name _____

Dental Plan Telephone Number _____

Your Member ID# _____

5. DEPENDENT INFORMATION — List eligible dependents you wish to include on your coverage. If necessary, attach another sheet of paper.

☐ Spouse ☐ Domestic Partner / Eligible Children	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions

FOR DIVISION USE ONLY

Event Reason ___ Effective Date ___

Location No. ___

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check — including initial check, last check benefit, withdrawal check, or return of contributions check — as required by the State Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ PLUS or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicible, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the State Health Benefits Program must be notified immediately.

Applicant's Signature _____ Date: _____

☐ Additional Sheet Attached ☐ Medicare Proof Enclosed

COMPLETING THE STATE HEALTH BENEFITS PROGRAM RETIRED STATUS APPLICATION

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

SECTION 2 — TYPE OF ACTIVITY

Check one box in section A. If you have applied for retirement or are a new retiree, check the first box "New Retiree".

If you are enrolling in the State Health Benefits Program as a Surviving Spouse/Domestic Partner/Dependent, check "Survivor Enrollment."

State Health Benefits Program coverage can be voluntarily cancelled at any time by checking "Cancel Coverage." However, if you voluntarily cancel your coverage, reinstatement into the State Health Benefits Program is not normally permissible.

For plan changes or to add or delete a dependent, check "Coverage Change" and enter the change information in section B.

For other changes check "Other Change" enter the change information in section C.

SECTION 3 — MEDICAL PLAN SELECTION

Check only one box indicating either:

- the medical plan into which you want to enroll; or
- that you do not want coverage. (See Declining or Waiving Coverage below)

When choosing NJ PLUS or an HMO you must list the identification number (ID #) of your Primary Care Physician.

DECLINING OR WAIVING COVERAGE: If you are declining coverage and do not want State Health Benefits Program coverage, check one of the boxes indicating that you do not wish to be covered under any of the medical/dental plans. If you are declining enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public employer*, you may in the future be able to enroll yourself and your eligible dependents in a SHBP medical or dental plan, provided that you request enrollment within 60 days after your other public employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in the SHBP When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *State Health Benefits Program Retired Coverage Under Chapter 330*, for more information.

**A public employer is a federal, state, county, or municipal government or authority; a local board of education; or a state or county college or university.*

LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. Your eligible dependents are your spouse (attach a copy of the marriage certificate if this is your first time enrolling in the SHBP), an eligible domestic partner (see note below), and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, legally-adopted children, and legal wards are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. An *Affidavit of Dependency* form and legal documentation are required for these cases if you have not previously provided this to the SHBP. You will be sent an *Affidavit of Dependency* if required once your application is received.

On your initial application at the time of retirement, you may add eligible dependents; thereafter, dependents may be added within 60 days of the date of event (i.e., marriage or birth of a child) with an effective date of the date of the event. Otherwise, eligible dependents can be added in the future, with a 60-day waiting period. Coverage will be effective the 1st of the month following the 60 days of the receipt of your application.

Indicate whether you and/or your spouse/domestic partner/child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of Medicare enrollment is required by the State Health Benefits Program. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B in order to have coverage in the State Health Benefits Program. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

DOMESTIC PARTNER: A domestic partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, the Domestic Partnership Act, as a person of the same sex with whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for more information). If covering a domestic partner as a dependent, you must attach a photocopy of your *Certificate of Domestic Partnership* to this application (if this is your first time enrolling in the SHBP). If you are retired from a local employer (county, municipality, board of education, etc.), your former employer must participate in the SHBP and must have adopted a resolution to participate in Chapter 246, in order for you to enroll a domestic partner.

SECTION 4 — DENTAL EXPENSE PLAN SELECTION

If eligible, check only one box indicating either:

- that you want to enroll in the Dental Expense Plan; or
- that you want to waive dental coverage. (See Declining or Waiving Coverage above)

Select a level of coverage based upon who you will be covering. See the "Level of Coverage" above for details.

SECTION 5 — SPOUSE AND DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse, Member & Domestic Partner, Family, or Parent & Child(ren) coverage. Please list your spouse's or domestic partner's name, gender, date of birth, Social Security number, and if appropriate, Primary Care Physician ID#. Please also list the name, gender, date of birth, Social Security number, and if appropriate the Primary Care Physician ID# for any dependent children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. Box 299
TRENTON, NJ 08625-0299
or Fax to: 609-341-3407